Patient Name: ______________________ **Date of Birth** ______________________

Are you experiencing any problems ______________________

Have you had any hospitalizations or surgeries since your last visit ? __________ If yes please explain: __________

____

Has any immediate family member been diagnosed with major illness or cancer since your last visit? ____ ______

If yes please explain: ______________________

Habits:

Alcohol: Type__________Amount__________________ Do you wear a seat belt?
Have you been a victim of domestic abuse: __________________ Do you use recreational drugs?__________________
Have you smoked in the past? __________ If yes, How long since quitting/ __________
Do you currently smoke:_______; if yes, Packs daily_____How long?________Interested in stopping?______
Coffee: Cups daily_____Other caffeine__________________
Exercise routine:__________________
How often:__________________

Have you had any of the following symptoms in the last 30 days?

❑Weight Loss ❑Weight Gain ❑Fever ❑Fatigue ❑Weakness
❑Dizziness ❑Short of Breath ❑Leg Swelling ❑ Irregular Pulse ❑ Chest Pain
❑Wheezing ❑Short of Breath ❑Cough ❑Difficulty Breathing
❑Abdominal Pain ❑Difficulty Swallowing ❑Diarrhea ❑ Bloody Stool
❑Nausea ❑Vomiting ❑Constipation ❑Heartburn
❑Bloating/belching ❑Blood in urine ❑Pain with urination ❑Urgency ❑Frequency ❑ Incontinence
❑Nocturia
❑Breast Pain ❑Nipple Discharge ❑ Lump
❑ Eating Disorder ❑Mental/physical Abuse ❑Anxiety ❑Depression
❑Crying ❑ Memory Loss ❑ Insomnia
❑Excessive Sweating ❑ Excessive Thirst ❑ Excessive Urination
❑Cold Intolerance ❑Heat Intolerance ❑Hot flashes
❑Bruises ❑ Bleeding ❑Enlarged Lymph Nodes ❑Varicose Veins
❑ Loss of Appetite